RELICENSURE REQUIREMENTS SHEET FOR FOSTER FAMILY HOMES

State Form 53155 (11-06) / CW 2312
DEPARTMENT OF CHILD SERVICES

INSTRUCTIONS: The relicensure process of a foster family home is to be completed within four (4) years of the initial licensure date, prior to the expiration date of the initial license and every four (4) years thereafter.

Date on which relicensure is effective (*month, day, year*)

Name of caregiver A	Name of caregiver B

Signature of licensing staff	Agency (county or LCPA)	Resource number

SUPERVISOR INITIALS	INITIAL LICENSURE REQUIREMENTS	APPLICANT A DATE RECEIVED (*month, day, year*)	APPLICANT B DATE RECEIVED (*month, day, year*)	DATE ENTERED IN ICWIS (*month, day, year*)
	Application			
	1. SF 10100 / CW 0317, Application for Foster Family Home License			
	Home Study			
	1. On-site Home Visit			
	2. SF 53186 / CW 3417, Foster Family Home Physical Environment Checklist			
	3. Water Analysis Approval OR Statement of City Water			
	4. Home Study Update (including annual reports)			
	5. SF 47344 / CW 0015, Substitute Care Agreement			
	6. SF 53214 / CW 3519, Licensing Staff Inquiry Regarding Foster Family Home			
	7. SF 53184 / CW 3415, Foster Care / Adoption Information, **(Financial Profile section only)**			
	Training			
	1. Required annual in-service training hours completed			
	2. CPR course certification			
	3. First Aid course certification			
	4. Universal Precautions course certification			
	Criminal History Background Checks (for all household members, employees, and volunteers)			
	1. SF 46151 / CW 0025, Applicant's Statement of Attestation			
	2. SF 53259 / CW 3610, Application for Criminal History Background Check			
	3. Results of Indiana State Limited Criminal History Information (14 - 17) (including Indiana State Juvenile History)			
	4. Results of City Police Department check (14+)			
	5. Results of County Sheriff's Department check (14+)			
	6. Report of Sex and Violent Offender Registry (14+)			
	7. Results of CPS check for EVERYONE in household, regardless of age			
	Medical Information			
	1. SF 45145 / CW 0039, Medical Report For Primary Caregivers			
	2. SF 45144 / CW 0038, Medical Report For Household Members			

Date all requirements for initial licensure are met (*month, day, year*)

Reason for return

Signature of supervisor	Date (*month, day, year*)
Signature of director or designee	**Date (*month, day, year*)**